City of Albuquerque Permission Slip, Medical Release, and Waiver Form

Permission for: _____(enrollee) hereby give the City of Albuquerque (the City) permission for enrollee (named above) to participate in the _____ Program of the City (the Program). I acknowledge that some activities of the Program may be off City property and give my permission for enrollee to participate in such activities.

Medical Release: I authorize the City staff to act on my behalf if medical treatment is necessary for enrollee. In the event of illness or injury to enrollee, I authorize the City to obtain medical treatment for enrollee and authorize medical services to be provided under the medical insurance identified below, or if none, at the expense of the Responsible Party identified below.

Liability Waiver. I agree to hold the City harmless for any injury or medical or other health care problems enrollee may incur during enrollee's participation in the Program, both on and off City property. I agree to pay all medical cost related to any injury or illness that enrollee may incur during enrollee's participation in the Program. I further agree that the City shall not be responsible for payment of medical services for enrollee and acknowledge and agree that any City insurance that may exist does not cover enrollee's medical costs.

Medical Information: Medical insurance that provides health care coverage for enrollee is shown on the attached health insurance card. The following is a list of all medical problems, allergies, medications being taken, and restrictions due to enrollee's health conditions: _____

_____

The enrollee may not take the following medications: _____

The name of enrollee's physician is: _____
Day Phone: _____ Night Phone: _____

Preferred Hospital: _____(Address/City)

Responsible Party: Identify who is the responsible party for payment of health care for the enrollee. Provide this information in addition to providing the medical insurance card. Provide this information even if there is not medical insurance.
Responsible Party: _____ Work Phone: _____
Relationship to Enrollee: _____ Home Phone: _____

Medical Care Contacts: List at least two people the City may contact in the event the enrollee requests medical care or the City determines that the enrollee is in need of medical care:

1. Name:_____Home Phone:_____Work Phone:_____
   Relationship to Enrollee:_____
2. Name:_____Home Phone:_____Work Phone:_____
   Relationship to Enrollee:_____

Authorization to Release Enrollee: In the event enrollee requires medical care, as determined by the City or requested by the enrollee, I authorize the City to release enrollee to the custody of any one of the people named above as Medical Care Contacts.

Signature:_____(Parent/Guardian) Date:_____

Print Name of Parent or Guardian signing above:_____

Witnessed:_____Date_____/_____/_____